Making HIV programmes work: The Heineken workplace programme to prevent and treat HIV infection 2001-2010
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Summary of this thesis

Introduction

In chapter 1 of this thesis the HIV epidemic in Africa is briefly reviewed. The history of preventative activities in the industrialised world and their application in low-income countries during the past century are mentioned. The World AIDS conference in Durban, the first on the worst affected continent, proved very important to increase access to live-saving treatment and many international initiatives sprang up after this event.

This was also the time that the corporate business sector started to take notice of the effect the epidemic had on its African operations. Economists warned about macro-economic effects, the social impact was examined and discussed and the impact on the workforce was beginning to show. Multinational companies were, understandably, the first to react, but smaller companies that, when taken all together, have a much larger employee base in sub-Saharan Africa were at pains to follow suit.

Some international organisations were created that wanted to bring businesses together, also non-governmental organisations like PharmAccess offered their expertise to the business sector. In this chapter some innovating workplace programmes are mentioned, these companies were setting important examples for their peer-companies.

Heineken is already present for 75 years in Africa and its operating companies are embedded in the local societies. The employees and direct family members were offered decent health care benefits, often provided by company medical staff. Nevertheless, the effects of the HIV-epidemic were felt over the years. Encouraged and challenged by PharmAccess, Heineken decided to embark on a treatment project in 2001 and to reinforce the prevention activities. One of the ambitions of the project was that other companies should be convinced to do the same.

Chapter 2 discusses the Accelerating Access Initiative (AAI). This initiative was a groundbreaking cooperation between pharmaceutical firms and UN agencies -- United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), World Health Organization (WHO), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) -- to improve access to antiretrovirals (ARVs) in poor countries. For Heineken, this was a very important initiative: the price reduction of brand-name ARVs made it possible to plan a workplace-based treatment programme. Although the AAI was key to the Heineken decision to start antiretroviral
treatment (ART) programs, there were multiple bottlenecks and logistical challenges. In particular, consistency of drug supply was cumbersome to maintain for the OPCOs: every pharmaceutical company had its own separate administrative procedures; importation of drugs by a brewery proved to be difficult; the delivery of drugs was often slow, and sometimes national governments were unhelpful. From the Heineken experience, it is clear that affordable drug prices are an important reason for the private sector to consider starting a workplace ART programme. The recommendations of the paper are that the private sector should have access to discounted ARVs under the AAI; a network should be created to assist in the logistics of drug ordering, purchase and clearance; and governments should abstain from levying import duties on ARVs.

Database-supported teleconferencing to support physicians

A serious obstacle to providing ART, particularly in the early days, was the absence of adequately trained health care staff. The correct use of ARVs, an emphasis on drug adherence, and proper interpretation of laboratory monitoring results are all critical for treatment success. Additional training and monitoring of Heineken’s health care staff was therefore necessary. For staff who could not be absent from the job for a long training session, initial training was provided in the form of a crash course. Also, it was opted to maintain and extend knowledge during program roll-out on a “learning by doing” basis. To support this approach, a clinical mentoring program, using regular teleconferences, was established in collaboration with PharmAccess. With this tool, as described in Chapter 3, one experienced clinician coaches several practitioners at the same time. Together they discuss clinical issues that appear in day-to-day practice and that lead to additional questions. Easy distant access to the patient files by the experienced clinician has added extra quality to this mentorship. The nature of the most frequently discussed topics was analysed and has helped to determine various knowledge gaps. These gaps were addressed during refresher training sessions that were subsequently organised. Conclusions are that mentoring offers the possibility to accelerate the implementation of new treatment projects; it avoids the absence from work that would be required by long or distant training sessions. The close monitoring helps clinicians to deal with issues such as ARV toxicity, diagnosis and treatment of tuberculosis, and the switch from first- to second-line drugs.
Coverage of voluntary counselling and testing at Heineken, Rwanda

Offering quality care for HIV-1-infected employees and their family members offers the most benefit if infected persons are diagnosed early. VCT is important to diagnosis, although its role in HIV prevention is probably limited. As described in Chapter 4, we followed the voluntary counselling and testing (VCT) activities in the Rwanda operating company (OPCO). To ascertain that VCT was indeed diagnosing the HIV-infected workers at the company clinic, a survey using oral transudate swabs was conducted in the adult target population at the Rwandan brewery. The survey produced an estimate of the number of HIV-infected employees; this estimate was compared to the actual number of HIV-infected employees registered at the clinic. It was found that the large majority of HIV-infected employees was already enrolled in the ART programme. Forty months after the start of the programme, the uptake of HIV testing by HIV-infected persons appeared to be good: 73% of employees and 62% of spouses took the test. They accounted for 87% of seropositive adults. A qualitative evaluation was carried out to learn what factors determined the decision to come forward for HIV testing. For employees, inhibitors of testing were the perception or experience of confidentiality breaches and fear of dismissal. Managers cited a fear of losing of status or job position if their HIV status became known. Enablers of testing identified from the qualitative survey were a presentation to employees given by an HIV-positive speaker, the efforts and presentations of the company medical officer, and the availability of treatment. Another key finding is that sick persons report earlier for testing. That is, HIV-positive persons with lower CD4 lymphocyte counts came for testing sooner, once the programme was available, than did those with higher CD4 counts.

Long-term uptake of voluntary counselling and testing in the African sites

In Chapter 5, the uptake of VCT by employees and spouses was analysed in all African OPCOs. It was shown that specific mobilisation events and efforts by staff can influence the uptake considerably. This has been shown in other workplace programmes (WPPs) as well. Uptake of HIV testing differed by employment status (i.e. more uptake by employees than by spouses) rather than by gender. Women in both categories were more likely to get tested than men. The peak of testing uptake occurred after the first year of the programme, probably because trust in the confidentiality and non-discrimination promises had grown over that year. If the routine uptake results are unsatisfactory, they can be considerably improved by linking and integrating HIV testing with other health care interventions (immunisation, annual check-up, and health education.
Mortality and morbidity among HIV-1-infected persons.

When the Executive Board of Heineken decided to add HIV treatment to the package of medical benefits, it stipulated explicitly that the programme had to be of good quality. The best indicator for the quality of an HIV treatment programme is the long-term survival of the patients. This was analysed in Chapter 6, and the results of the Heineken workplace programme (HWPP) are very good compared to other results reported from sub-Saharan Africa (SSA). The mortality rate of patients on ARV treatment was 3.7 per 100 person-years, with a higher mortality during the first 16 weeks of HIV treatment (14 per 100 person-years). In terms of survival: four years after the diagnosis, 89% of the patients were still known to be alive and on HAART. With survival comparable to cohorts in other low-income countries, the programme has lived up to the quality requirement of the Executive Board of Heineken. A cohort in Botswana reported comparable results in mortality but much higher loss to follow-up, which occurred mainly before people were put on highly active antiretroviral treatment (HAART) (33/431). This phenomenon has also been observed in other cohorts. Once on HAART, the HWPP loss to follow-up was very low (7/249) when compared to long-term retention in other African ARV therapy programmes. An in-house workplace programme provides possibilities for intensive follow-up and tracking of defaulters; communication with colleagues can be used to reduce treatment failure caused by poor adherence. The importance of such communication and readily accessible health services has been described in similar settings.

AIDS-related morbidity is an indicator for the health status of a patient. After starting HAART in the HWPP, the incidence rate for new AIDS-defining events was low (1.9 per 100 person-years). Of the 9 incident cases, 5 were due to TB. Studies in other low-income countries have
likewise cited TB as one of the important opportunistic infections. For a workplace-based programme, the survival of employees and the maintenance of their health status are the economic drivers. As a conclusion of this chapter, it can be stated that HWPP leads to reduction of mortality and morbidity. From the business point of view, such reduction allows the continuation of a productive life.

Chapter 7 reviewed and refuted 11 reasons that are invoked by large international companies to justify putting off the start of an HIV treatment programme. In 2010, these arguments in favour of HAART provision retain their validity. The HWPP proves that it is possible to deal with the complicated nature of treatment protocols. The costs of ARV are affordable for a company. Africans have essentially the same capability for adherence as patients on other continents, and a good WPP can provide sufficient attention to encourage this adherence. Many businesses enjoy a long-term presence in Africa, so the sustainability of a WPP is not a major issue. So far, Heineken’s well-run programme has not encountered major issues with drug resistance. The advantages enjoyed by employees can encourage or pressure governments to match these benefits for their own employees. Public health is the responsibility for all: employers should deal with all diseases affecting the health of their workforce community. They should not deny effective treatment for any reasons linked to moral judgments or disapproval if, for example, a disease is transmitted by sexual contact. Finally, the treatment offered by HWPP has reinvigorated all HIV prevention efforts, showing that these two components need not be in competition.

For a large company not to include ARVs in the health care benefits for their employees and spouses is inexcusable. The conclusions of this viewpoint are that treatment of HIV with ARVs should be part of the medical benefits the workers can enjoy.

Refuting reasons for postponing art programs for HIV-infected employees

General discussion

The contents of a decent and relevant workplace programme are by now well known, but many companies struggle with the more challenging part of treatment of HIV-infected. This has been implemented well in the Heineken Workplace Programme. But improvements can still be realised. Study of the available data may have operational consequences: these data are collected and will be analysed in the years to come. In the workplace the objective of zero new cases should remain the target. Attention should focus on all effective measures to reduce transmission. Treating one partner in a
discordant couple protects the non-infected partner; mother to child transmission should be reduced to near zero cases; incidence of tuberculosis in treated patients should be prevented. At the same time it appears that the mortality reduction can be sustained during a long time.

One way to increase the impact of a workplace programme is to partner with the companies that are suppliers or clients of the larger company; important gains in terms of prevention or treatment could possibly be made this way.

The Executive Board of Heineken requested the medical department and its partners to take an advocacy role and convince other companies to adopt the same policies. A strategic tool, the Strengths, Weaknesses, Opportunities and Threats analysis, can be useful to make a case for other companies. An example is included in the final chapter, chapter 8.

The battle against HIV is far from won. Some complacency is creeping in, the successes of the past years have concealed the fact that the number of people needing treatment is still growing. Sustainable success will only be possible if a broad coalition of donor countries, recipient countries, non-governmental organisations, public and private sector, and activists continues to exist and cooperate. All have a part to play and no one can succeed without the support of the others.